**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

DR AHMED KHALIFA
1415 SOUTH HWY 6 SUITE 400D
SUGARLAND TX 77478

**Respondent Name**

ACE AMERICAN INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 15

**MFDR Tracking Number**
M4-11-2312-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Fee Guideline."

**Amount in Dispute:** $159.91

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Enclosed please find the completed Medical Fee Dispute Resolution Request/Response (FORM DWC060) and payment screen confirming that the dispute has been resolved."

**Response Submitted by:** Ace American Insurance Co., Stone Loughlin & Swanson, LLP, P.O. Box 30111, Austin, TX 78755

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 10, 2011 | CPT Code 99214 | $159.91 | $19.52 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Division rule at 28 TAC §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 2, 2011
- 216-Based on the findings of a review organization.

**Issues**

Is the requestor entitled to additional reimbursement for CPT Code 99214?

**Findings**

On the initial EOB the respondent denied reimbursement for the office visit coded 99214 based upon "216." A review of the respondent's position summary and payment screen indicates that the respondent reconsidered the bill and issued payment of $139.91.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77478, which is located in Fort Bend County.

The MAR for CPT code 99214 in Fort Bend County is $159.43 (WC Conv 54.54/Medicare Conversion 33.9764 X $99.32 participating amount). The respondent paid $139.91. The requestor is due the difference between the MAR and amount paid of $19.52.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $19.52.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $19.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 10/26/2011<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.